The power of food: mediating social relationships in the care of chronically ill elderly people in urban Indonesia

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The power of food: mediating social relationships in the care of chronically ill elderly people in urban Indonesia

Peter van Eeuwijk

Abstracts

Français | English

The preparation of food and drink is regarded as pivotal to care of chronically sick elderly people in urban Indonesia. Their meals are cooked solely by close household members. The majority of the elderly sick take part in the joint daily meals that serve as important arenas of social interaction and information sources. Continued commensality and participation in the sharing of food during festivities and ceremonies thus represents a vital source of social identity and social involvement for older people. However, many of the chronically ill elderly patients in this study have to comply with certain dietary restrictions. Chronic disease such as hypertension, diabetes and rheumatism thus change the nature of the patient-carer relationship by introducing the notions of trust and control. The patient has to trust the special, "healthy" treatment, that is to say, the healthy diet that is provided by his/her caregiver. On the other hand, the caregiver exerts power by controlling dietary intake, thus monitoring the elderly patient's compliance with prescribed therapy.

Index terms

Mots-clés : personnes âgées, maladies chroniques, soins, régime, pouvoir et contrôle, inclusion et exclusion sociale, Sulawesi du Nord, Indonésie

Keywords : diet, elderly persons, chronic disease, care, power and control, social inclusion and exclusion, North Sulawesi, Indonesia

Outline

Editor's notes

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Full text

Introduction

1 Food and nutrition represent two essential spheres of human life that can hardly be separated from their cultural context. “Next to breathing, eating is perhaps the most essential of all human activities, and one with which much of social life is entwined” (Mintz and Du Bois, 2002: 102). Eating is not merely calory intake, it is deeply rooted in everyday life: with every mouthful, we also ingest culture. As Helman (2000: 32) concludes: “Food, therefore, is an essential part of the way that any society organizes itself, and of the way it views the world that it inhabits.” Social relations can be reproduced and represented through food, and food conversely creates and shapes coherence and identity within and between societal units such as households, kin categories, age classes, professional groups, or informal associations.

2 Food, nutrition and social relations do not constitute a neutral or value-free sphere where, for instance, the access to food, the giving and receiving of food, or the mode of consumption are considered to be equal between social units. Food and nutrition are strongly shaped and marked by power. In other words, they are effective instruments for manifesting and exerting power, and for generating and evaluating trust among individuals, groups and even nations. Thus, social groups or classes with deprived economic standing and low social status – such as “women, people of color, the mentally ill, the handicapped, and the elderly” (Counihan, 1999: 8) – may suffer from a permanent or temporary lack of food (in terms of quantity and quality) due to their inability to exert power. Consequentially, Counihan (1999: 7) calls hunger the absolute sign of powerlessness. Voutira and Harrell-Bond (1995: 211) describe the approach of international donors to food distribution in refugee camps in Rwanda as a disguised strategy of “keeping while giving” thus generating a general atmosphere of distrust and suspicion.

3 Elderly people are a case in point. Their particular needs highlight the relationship between food and nutrition and health and illness. From an aetiological point of view the quantity and quality of food may be causative factors in acute and chronic diseases (eg diarrhoea, hypertension, obesity). Conversely, food may play a therapeutic (eg diet, herbal plants) and/or preventive role (eg vitamins, proteins) (Etkin and Ross, 1982; van Eeuwijk,

1999: 133, 147-149; Helman, 2000: 36-37). Due to the vital interrelation of health and food, nutrition and eating are particular priorities for elderly people whose health does to some extent depend on the quantity and quality of food intake. For the elderly sick the regular provision of the right (healthy, restorative) foods is as essential as the withholding of the wrong ones. This means that the patient-carer relationship is largely defined by the giving and receiving of food and nutrition, which generates very powerful interpersonal relationships between the giver (spouse or child) and the receiver (elderly patient). These relationships in turn do much to determine the degree of social inclusion or exclusion of the person in need of care.

4 Age is another dimension of the care relationship. Established inter-generational connections, for instance between children and their aged parents, entail other powerfully normative factors such as respect and reciprocity, filial piety and kinship obligation. According to Pyke (1999) the degree of power exerted in a care relationship between an elderly patient and his or her children varies with the nature of the relationship itself. In short, parents in collectivist families [1] receive a higher level of care but exert less power. Individualist parents, on the other hand, have more power but receive less family support and care from their children due to the fact that they are more independent and self-reliant: they do not have "to win their children's approval and commitment to care" (Pyke, 1999: 670).

5 Generally speaking, power is an integral part of social support and it is further reinforced by the care relationship, impacting strongly on the modes of nutrition of the elderly sick (Steen, 2003). This paper sets out to show how the social life of food and its inherent power dynamics shape and influence support relationships between caregivers and chronically sick elderly patients, and why these processes develop in the way they do.

Elderly persons, food, and illness

6 Ebersole's statement (2003: 260) that "eating is one of the first and last pleasures of life" seems to have become an obsession for better-off American and Western European middle and upper class senior citizens. The fact is, however, that many elderly people – in developing, transitional and developed countries – suffer daily from temporary or permanent malnutrition (McElroy and Townsend, 1996). This became evident through reports by both the WHO (2003a, 2003b), and HelpAge International: "Many older people do not have access even to the most basic need of all – food" (HelpAge International, 2002: 24). The main causes of poor nutritional status in elderly people are poverty and material scarcity, social exclusion, ill health, and disability. Unequal gender relations, conflicts and disasters are also to blame. Poor nutrition and imbalanced diets also have direct multiple effects on the health of elderly persons, promoting diabetes, heart disease, hypertension, and osteoporosis (WHO, 2003a: 12). In most cases, this will result in irreversible progressive chronic illness and physical frailty. For Husmann and Truttmann (2005: 58) the nutritional status of elderly people ranks as one of the four key frailty factors.

7 The fact is that households in developing countries are not safe havens where elderly people can depend on a provision of food and health care that is appropriate to their needs (van Eeuwijk, 1999, 2003a). For many elderly people, the psychosocial protection provided by the household comes at the price of harsh material restrictions and limited livelihoods (Lupton, 1996). Intra-household inequalities in the distribution of adequate nourishment depend on status ascriptions such as gender, age, marital status, economic pecking order, physical strength or birth order (Panter-Brick, 1996). Elderly people, for instance, tend to be regarded (and treated) as weak, passive household members who are net consumers. This is particularly true in deprived households, generally leading to the inadequate provision of food in terms of quantity and quality.

8 The provision and consumption of food in relation to elderly people has become an increasingly prominent factor in contemporary global transformations of health-related fields. These processes have an immediate and extensive impact on the majority of developing countries. An appropriate conceptual framework for health transition integrates demographic (eg increases in life expectancy), epidemiological (eg increases in chronic disease) and social transformations (eg new household compositions) with rapid urbanisation, widespread migration and changes in lifestyle (Wilkinson, 1994; Caldwell, 2001; van Eeuwijk, 2003a, 2003b, 2004). Changes in nutritional habits represent a core dimension of lifestyle change and have a particular impact on elderly people living in modern urban areas of developing countries. Changes in eating habits among better-off elderly people in particular have led to over-eating and the over-consumption of fat, oil, salt, sugar and starchy foods. This, combined with reduced exercise, gradually leads to diet-related, lifestyle diseases of a predominantly chronic, progressive and deteriorating nature (WHO, 2002, 2003a; see, for instance, Muhilal [1996] and Boedhi-Darmojo [2002] for Indonesia and Worsley [2001] for the Asia-Pacific region). Alongside the more common age-related disorders (such as impaired vision and hearing, dental and oral problems, dementia and musculoskeletal disorders) are newly emerging chronic diseases such as obesity, diabetes, hypertension and cardiovascular problems. These have led to a rapid increase in the numbers of elderly patients in developing countries who need temporary or continuous care – a change claimed by Helman (2000: 8) to indicate "a major shift in the medical paradigm [..] – a shift from 'cure' to 'care'".

The concept of care and the household production of care

9 In the following section, we refer to Joan Tronto's theoretical framework of care. She argues that care is an interplay of practice and disposition (intention), where both dimensions have to exist simultaneously (Tronto, 1993: 104). Building on her conceptual framework, Niehof describes "care as both attitude and practice" (2002: 181) – an approach based on discourse, actions and intentions. She outlines a process of care with four interconnected phases (2004: 247; see also Tronto [1993: 105-108] and Pennartz and Niehof [1999: 191]):

- Caring about: assessing the need for care – requires *attentiveness* on the part of the caregiver.
- Taking care of: determining how to respond to the need for care – requires *responsibility* for the kind of action.
- Care giving: meeting the need for care – requires *competence* on the part of the caregiver.
- Care receiving: assessing the appropriateness of care – requires *responsiveness* from the care-receiver.

10 Van der Geest (2002: 8) calls this dynamic framework of care, a process "moving from awareness and intention to actual practice and response". Care is a "process that sustains life" and that reflects "the moral quality of life" (van der Geest, 2002: 8).

11 The social dynamics of nutrition, food allocation, and health are theoretically embedded in the concepts of the household production of nutrition (Bentley and Pelto, 1991). The household production of health (Berman et al., 1994) which includes food, nutrition and feeding – as well as the care and support of healthy and sick household members – is another key commodity and must be deliberately produced by every household through a combination of available material resources (eg money, assets, transport) and non-material resources (eg time, labour, social capital and knowledge) (Berman et al., 1994; van Eeuwijk, 1999). Households can therefore be seen to represent important resource systems in the management of health and play a key role in the production and provision of the nutrition required for the care and support of

the elderly sick.

12 Niehof (2002, 2004) uses this concept of the household production of health, as the basis of what she terms the household production of care: care, like health, is a commodity that must be deliberately produced by all household members and it includes the provision of food and nutrition for sick and frail family members. The main impetus for the production of care is, on the one hand, close marital and familial ties and, on the other, the moral economy that aims at cementing certain social relations, instead of pursuing self-centred interests (Niehof, 2002: 182). In this context, production does not refer to a purely mechanistic input-output oriented process. It refers to the deliberate allocation of practices and attitudes on the part of caregivers and care-recipients alike – which may result in positive or negative outcomes. From a normative point of view, the diverse course of care is shaped by highly conceptual norms such as filial piety or kinship obligations. In practice, the care and support of the elderly sick may be negotiated and re-negotiated among family members and relatives. For example, the purchase, preparation and serving of food are all prominent issues within this negotiation process which includes such questions as who shops, pays, prepares, cooks and serves the food. Care as a process of recurrent negotiations is a particular feature of bilateral kinship settings, where both the paternal and the maternal side bargain consistently over the responsibility for support (see, for instance, Niehof [1995] and Schröder-Butterfill [2002, 2004] on elder care in bilateral kinship systems on Java [Indonesia]).

13 A second normative inter-relational aspect of elder care has to do with gender. As concluded by Niehof (2002: 181), "the whole [care] process is gendered", and it is impossible to understate the crucial role played by women in the support and particularly long-term care of the elderly sick. In developing countries, health transition means an increasing shift in emphasis from infectious disease to more intractable, chronic disease in older people. This, combined with longer life expectancy particularly for women, means that distinctly more elderly women than men are now in need of long-term care [2]. In addition the majority of women (but not men) are widowed (Phillips and Chan, 2002; van Eeuwijk, 2003a). Women, including elderly women, play a central role in the management and care of the elderly. Two points must be borne in mind here. The first is that elder care places considerable social, economic, psychological, and physical burden on the caregiver. The second is that the majority of caregivers are female laypersons who do not always have the necessary skills to provide adequate and appropriate long-term care for chronically sick, elderly people.

Study area and design, methods and sample characteristics

14 "Growing Old in the City" was the title of a three-year research project (2000-2002, 2003) mainly focussed on the vulnerability, health, care and support of the elderly in three urban centres in the North Sulawesi Province of Indonesia (Island of Sulawesi [formerly Celebes]): the municipality of Manado, a busy, trendy provincial capital, with a population of 390,000; Tomohon, a semi-urban, provincial district capital in the Minahasa regency with some 74,000 inhabitants; and Tahuna, the remote capital of the Sangihe-Talaud Archipelago regency, with some 29,000 inhabitants (van Eeuwijk, 2003c). The selected locations reflect different degrees of ethnic and religious heterogeneity (eg Moslem, Christian and Chinese Buddhist) and varying stages of urbanism (van Eeuwijk, 2003b). The lower age limit for inclusion in the study was 60. This corresponds with the official definition of *lansia* (acronym for *[orang] lanjut usia*: [people of] advanced age) by the Indonesian Health Department.

15 The research approach was in four parts and encompassed different levels of society (van Eeuwijk, 2002, 2005, 2006):

-

A community study in seven political communities in three towns in the North Sulawesi Province.

- A household study based on 50 households per town (*N*=150), each including at least one elderly person.
- A cohort study based on 25 (currently) chronically ill elderly persons per town (*N*=75), selected from the household study sample.
- A tracer illness study based on 14 chronically ill elderly persons per town (*N*=42), each one selected from the cohort study sample and currently suffering from specific chronic disorders requiring care and support.

16 The selection of households and individuals was based on stratified random sampling (parts 2 and 3) and purposive sampling (part 4). The interdisciplinary research team [3] applied a combination of quantitative research methods (eg biomedical screening, ante-post-assessment of biomedical intervention, questionnaires) and qualitative techniques (eg structured and in-depth interviews, focus group discussions, direct observation, diary keeping, self-reporting, case studies and verbal autopsy inquiries); also, documentary tools such as photography and film documentation. With the exception of the case study information derived from the tracer illness study, the present article focuses mainly on household and cohort study members.

17 The demographic characteristics of the 40 respondents [4] in the tracer illness study are as follows (van Eeuwijk, 2003c, 2005): average age 69; oldest respondent 89; a roughly equal man-to-woman ratio (52%) but three times as many widows as widowers; religious and ethnic affiliation reflects those of the towns under study: 63% Christian, 33% Moslem and 4% Buddhist, with 80% belonging to the two predominant local ethnic groups, Minahasa and Sangihe; in terms of economic standing, 38% of cohort members had less than 50,000 *Rupiah* [5] to spend per week, a few (15%) had no monetary means of their own while others (very few) spent more than 100,000 *Rupiah* per week; the majority of respondents (80%) suffered from more than one health problem (co-morbidity).

Food and care of the chronically ill urban elderly: an analysis

18 The health profile of the elderly sick in urban North Sulawesi (Indonesia) who sought treatment at a public district health centre *(puskesmas)* showed a high prevalence rate of upper respiratory infections, hypertension, rheumatism and gastritis (van Eeuwijk, 2003c: 332). This diagnosed burden of disease differed partly from the self-reported burden of illness in our sample: the respondents attributed the highest degree of perceived severity to rheumatism, eye complaints, diabetes, hypertension, stomach troubles and asthma (van Eeuwijk, 2003b, 2003c, 2004). It should be borne in mind that minor disorders that deteriorate with age (sensory loss, dental, oral and locomotor disorders), cause serious difficulties for elderly people in terms of purchasing and preparing food in the urban environment. [6]

Elder care activities

Plate 1: An elderly ill widow is still carrying out her daily kitchen work (in Tahuna).

Zoom Original (jpeg, 352k)

19 For older persons in need of care, the preparation of food and drink is of great importance as are laundry and the administering of medication (see Table 1). More than two thirds of respondents regarded the preparation of food as one of the most important care activities provided by the different caregivers in their household. Cooking, as an Instrumental Activity of Daily Living (IADL), acquires acute, even existential significance for elderly individuals who lack, or have lost, the ability to prepare food and drink for themselves (van Eeuwijk, 2006). The purchasing, preparation and serving of food all require a certain degree of physical strength and mental vitality on the part of the person responsible. Not surprisingly, elderly people are all more likely to lack such abilities as a result of illness.

20 In all but a few of the study households, the preparation and cooking of meals was not confined to a single household member and could take place at any time of day. [7] In most of the households under study, the preparation of food and drink for elderly care-receivers required no special arrangements. The only, but nonetheless significant exception to this rule, were households where the elderly sick had special dietary needs or suffered from severe disabilities.

Table 1: Main activities of care and support provided by caregivers in households with at least one elderly person

Activity	Total *N*= 150	MANADO (*N*= 50)	Tahuna (*N*= 50)	Tomohon (*N*= 50)
Laundry	110 (73%)	37	37	36
Administering of drugs/medication	106 (71%)	39	34	33
Preparation of food/drink	103 (69%)	45	26	32
Moral support and recreation	98 (65%)	46	29	23
Massage	84 (56%)	23	26	35
Dressing and undressing	62 (41%)	24	14	24
Lavatory assistance	59 (39%)	25	16	18
Bathing	58 (38%)	22	16	20
Preparing for bed	42 (28%)	19	10	13

Note: Interviewed persons could give multiple answers.
Source: Author's research data, 2000-2002.

21 As indicated in the table (see Table 1), elderly people continue to perform tasks of a personal nature (dressing, visiting the lavatory and bathing) for as long as they are physically able to do so. Caregivers and elderly persons alike, however, tend to regard the preparation of food and drink as a task of a less personal nature.

Frequency, quantity and quality of meals

22 Almost three-quarters of the subjects under study had three meals per day (see Table 2): breakfast *(sarapan*, *smokol)* at around 6:00am, lunch *(makang siang)* at around 12:00pm and dinner *(makang malam)* at around 6:30pm.

Table 2: Number of meals per day

Meals per day	Total *N*= 150	MANADO (*N*= 50)	Tahuna (*N*= 50)	Tomohon (*N*= 50)
Two	8 (5%)	6	1	1
Three	109 (73%)	39	35	35
Four	22 (15%)	5	7	10
Five	11 (7%)	--	7	4

Source: Author's research data, 2000-2002.

23 The fact that the number of meals per day was the same as for most of the other household members confirms that, as stated above, the elderly persons under study had no special dietary needs. That said, these general findings from Indonesian households do tend to contradict the literature cited earlier, especially in relation to households in Sub-Saharan Africa and Southern Asia (HelpAge International, 2002; WHO, 2003a).

24 Elderly people in Tahuna and Tomohon in particular, sometimes ate four or five times a day (see Table 2) in line with the general household pattern of food intake. In Tahuna, where many families make their living out of sea-fishing (including selling fish at the market), the strenuous work at night and in the early morning creates the need for additional meals *("kerja banya*, *makang banya")*. In Tomohon, the eternally windy, cool and humid highland conditions (at 800-900 meters altitude) lead to increased appetite *("capat rasa lapar karna depe wer sejuk")*.

25 An average meal for elderly persons in urban North Sulawesi includes white rice *(nasi puti)*, fresh sea fish *(ikang laut)* and one or two varieties of vegetables *(sayor)*.[8] Additional minor foods include fruit *(bua),* such as papaya *(papaya)* and banana *(pisang)*, or cassava *(ubi kayu)*, taro *(ubi bete)* or sago *(sagu)* instead of white rice. In terms of composition and content, meals for elderly people are much the same as for other household members but with some notable exceptions.

Plate 2: After church gathering in Tomohon these elderly women enjoy a common snack from lunch box.

Zoom Original (jpeg, 176k)

26 Generally speaking, the elderly sick do not like modern convenience food, such

as pre-packed instant noodle dishes *(mie instan)* or the increasingly popular European breakfast of white coffee *(kopi susu)*, white bread *(roti puti)* and butter *(mantega)*. Furthermore, more than 90% of the elderly sick avoid meat *(dageng)* unlike children and adolescents who eat meat more frequently. There are two reasons for this. Firstly, meat in general and beef *(ikang sapi)* and pork *(ikang boke)* in particular, is now so expensive that households cannot afford to provide meat dishes for the whole family. Secondly, older people frequently point out the negative health effects of meat which they accuse of stimulating hypertension, diabetes, heart problems and rheumatism. [9] Chicken *(dageng ayam)* is the only exception and consumed on average twice per month by elderly people at the many festivities *(pesta)* or ceremonies *(acara)* where huge quantities of chicken are served free of charge. For many urban, chronically sick elderly people the consumption of chicken provides a powerful incentive to attend festivities and accept invitations. Additionally, even elderly people in poor health will attend such events so as to maintain their social networks (eg in kin and peer groups), seek entertainment and fulfil their duties as guests of honour.

27 It is important to bear in mind that most of the food in urban North Sulawesi has to be purchased. Money with which to buy food at the market is therefore a prerequisite for the daily household production of nutrition. In view of this it is not surprising to find that many of the elderly sick in our household study sample contributed substantially to the household budget: 43% regularly contributed material and financial resources – including money or food – as well as immaterial assets (van Eeuwijk, 2004). This monetisation of food is an essential characteristic of urban communities and leads in some cases to temporary food shortages. We identified six elderly patients who could not afford to buy fresh food every day and suffered from temporary underfeeding. They all had the following features in common: widowhood, chronic illness [10], poverty and head of household status. All of them lived in slums *(daerah kumuh)* and had no social network to speak of. Elderly patients in female-headed households such as these are particularly vulnerable to temporary food shortages. For them, the household is rarely the unconditional haven of safety it is supposed to be, as the following cases illustrate:

> *Ibu* I., widow, 68 years, Minahasa, Moslem; paralysed in one leg, rheumatic and a migraine sufferer: "*My unmarried daughter, an economist, lives with me in these two small rooms and takes care of me. But she has no job and cannot afford fresh food every day; then we eat only some fried banana or cassava. Sometimes she stays away for several days – maybe she has a boyfriend – and I remain lonesome and hungry (rasa sepi dan lapar). I do not cook because I cannot walk, I am partly bed-ridden and too weak. When I am too hungry, I call some girls in the neighbourhood to bring some cold rice left over in their kitchen (sisa nasi yang so dingin)*."
>
> *Ibu* J., widow, 68 years, Sangihe, Pentecostal; suffers from lung tuberculosis, cardiac and rheumatic problems, gastritis and hyperthyroidism: "*I live on the income from my small kiosk (warong). In my household, I have to feed 12 entrusted grandchildren and grandnephews every day. On some days, I can't even afford to buy enough rice and fish for us all. Then I cook for the children and I do not eat at all, even though I feel very ill and weak (so rasa saki dan swak skali). But I don't want to ask my neighbours for some food, I feel so ashamed!*"

28 Elderly widows can usually rely on their daughters to provide them with the quality and quantity of food they require on a daily basis. As a result, however, the daughters' absence (whether temporary as in the case of *Ibu I.* or permanent as with *Ibu J.*) can cause the mother to suffer from temporary undernourishment and/or malnutrition. What these two examples also show is that having to rely on neighbours for food makes elderly women even more vulnerable and leads to feelings of shame (Schröder-Butterfill, 2004: 135-136).

29 The quality of meals is hardly ever criticised by elderly care-receivers. We never heard complaints about tasteless food or less than delicious meals. One

of the reasons for this is years of familiarity with the taste of certain foods, which is sustained even in times of chronic illness. On the other hand, the particular relationship between sick elderly persons and their caregivers reflects both power and trust, and is voiced in statements such as: "Please take this meal as it is – you will like it!" Elderly male care-receivers often express a particular gender accentuation, stating for example "My wife knows perfectly well how to cook for me!" and "What my wife likes to eat – I like too!". We may conclude that, in most cases, taste satisfaction in such relationships is not a problem because the caregivers in question are usually very close family members (eg wife or/and daughter) who are well acquainted with the patient's nutritional likes and dislikes. Explicit complaints were rare and nearly always voiced by elderly men as an expression of their influential role as former bread-winners and heads of household: "This rice is boiled too soft *(nasi talalu lembo)*" or "I won't eat this fish, too salty for me *(ni ikang talalu bagaram)*!". We may assume that an elderly woman does not dare to protest or complain for fear of jeopardizing her weak position as a tolerated household member but also a net consumer. Whether or not to complain about the quality of daily food clearly reflects a gender-specific aspect of power.

Socialising during meals

30 Socialising with family and household members is one of the essential aspects of eating. Two-thirds of the respondents in the household sample stated that they communicate and socialise during meals. Often they eat together in the same room, in rare cases they even sit at one table. Thus for the vast majority of elderly people eating is a highly significant social and psychological event where they meet family members, exchange stories and news, and listen to the experiences of others. Indeed, this sort of participation and involvement in food intake and nutrition – sometimes in an active, occasionally in a more silent manner – is regarded as an essential safeguard against exclusion, isolation and neglect. As the following comments show, when important decisions are made during meals in Minahasa and Sangihe households, the elderly person still plays an important advisory role.

> Seventy-six-year-old fisherman from Tahuna: "*When we have breakfast in the late morning, my two sons tell me about the previous night's fishing and my wife tells me about selling fish at the market in the early morning. Though I am an old frail fisherman, I can give them advice if they want it (kase nasiha kalo dorang mau).*"
>
> Elderly man from Manado: "*After evening prayer (sholat Maghrib), I call my family to have dinner at 6:30pm and we mainly discuss meaningful things.*"
>
> Disabled elderly woman from Tomohon: "*Due to rheumatism (so basupi) I cannot walk properly, so I don't leave the house anymore; my daughter provides me with important information from our church congregation (jemaat), particularly at lunch or dinner after church gatherings; I always want to know who is going to be baptised, who is getting married and who has recently died.*"
>
> Elderly, visually impaired widower from Manado: "*Every evening at dinner, my grandchild tells me (bacaritra) about the important news in the newspaper; I cannot read anymore, so I give him the money to go to buy the newspaper.*"

31 However, an increasing number of elderly care-receivers complain that their only social duty at mealtimes is to watch over and entertain their grandchildren *(jaga cucu)* while their parents are out (whether at work or otherwise). Additionally, watching TV *(ba'uni televisi)* while eating has become a popular habit in many Indonesian households – a custom that considerably limits the socialising effect of sharing food.

32 One third of elderly persons in our household study either could not or would not participate in family mealtimes. There were several reasons for this:

- a physical and/or mental disability which prevented the elderly patient's presence at the table (see below);
- different mealtimes from those of the other household members;
- the elderly person lived alone and daily meals were brought in (see Table 3);
- the elderly person preferred to have meals apart, either in their own room or a separate corner of the house;
- deliberate exclusion from family mealtimes either because of intra-household tensions or so-called bad table manners on the part of the elderly person.

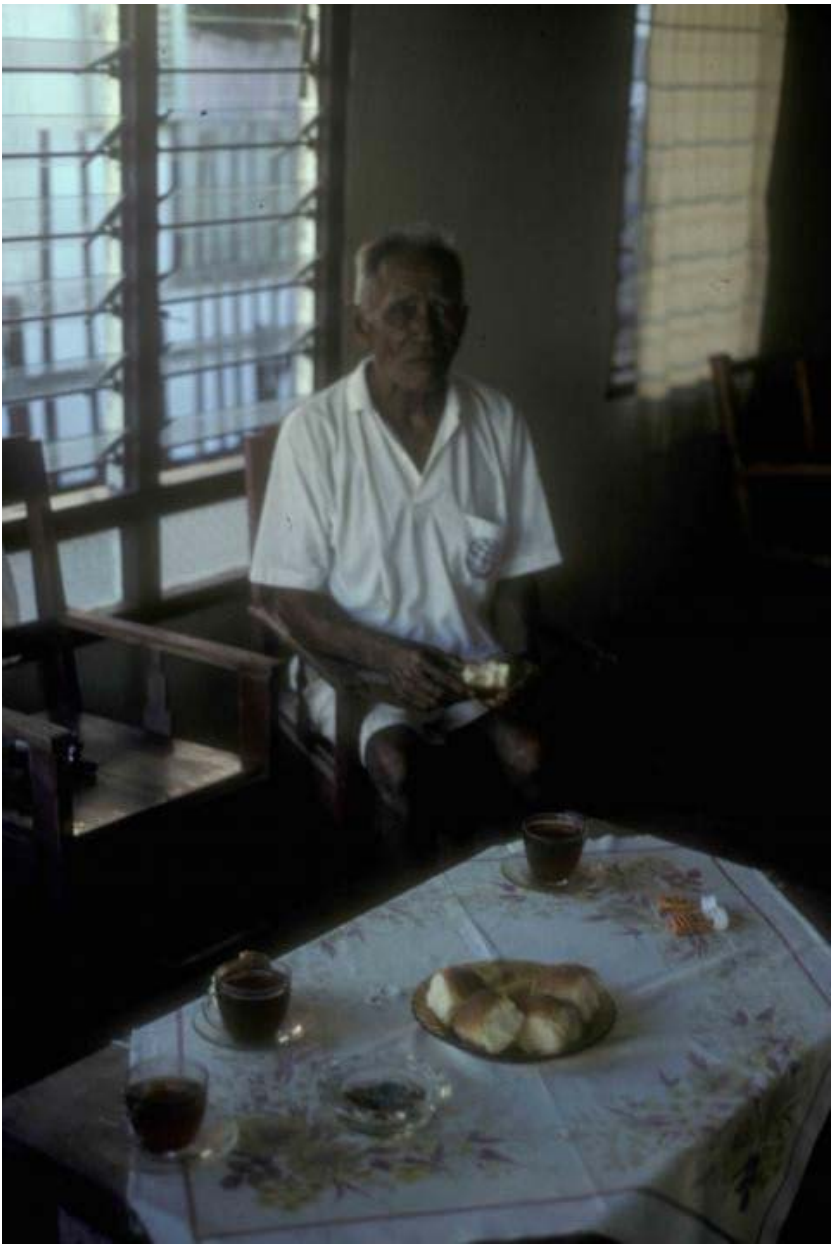
33 Elderly people who do not participate in family mealtimes have little influence on family matters, receive less information and news and may gradually come to feel excluded from other household members. Ultimately this can result in a certain degree of alienation from the wider social environment.

34 Nevertheless, the fact that the vast majority of the elderly sick continue to participate in daily meals reflects the social significance of food. For many elderly people, these three (or more) meals per day are both important landmarks in their daily routine and serve as an essential interface between those external and internal household relationships on which the flow of information depends. As the following comments show, attendance at fixed mealtimes brings a certain unalterable order to the routine of ill elderly people:

> Post-stroke paralysed 76-year old woman from Manado: "*From morning to night, my life is so boring (bosan) and mind-numbing that the three daily meals mean a welcome change.*"
>
> Elderly diabetic, obese man who still works as a tailor in Manado: "*Sharing three meal times with my child, my daughter-in-law and the grandchildren is the only occasion for me to meet (baku dapa) them and to hear news from outside (trima kabar dari luar).*"
>
> Hypertonic former fisherman from Tahuna: "*I know that I have to be at home at 12:30pm for lunch, otherwise my daughter will be angry with me (mara deng kita).*"

Diet and food prescriptions

Plate 3: White bread and red vitamin pills: an elderly widower on a diet has snack with guests (in Tahuna).



Zoom Original (jpeg, 264k)

35 In our cohort sample, half of our chronically sick elderly persons (51% or 38 patients) were either on a diet or had to comply with special dietary requirements. In most cases these were prescribed by a health professional although a few patients followed diets based on the advice of their age peers.

36 The most important dietary requirements related to the quantity and regularity of food intake and the composition of diets. For example, people were advised to avoid large meals but to ensure a regular intake of food *(ator makang*, *makang deng terator)*. They were also recommended to cut down on foods that were salty *(kurang bagaram*, *kurang asin)*, fatty/oily *(kurang baminya*, *kurang vet)*, sour *(kurang asam)* or sweet *(kurang manis)*. Since the generous use of hot spices, sea salt and coconut oil *(minya kalapa)* is an essential aspect of North Sulawesi cuisine, catering for the diets of chronically sick elderly patients means special, individually prepared daily meals. Spicy dishes served with very hot chilly sauce *(sambal*, *dabu-dabu)* no longer figure on the list of favourites of chronically sick elderly people.[11] In many cases this entails extra cooking, such as preparing rice porridge *(bubur)*, non-spicy and non-salty soups and non-fried vegetables and fish. Chilly sauce is consumed sparingly or not at all due to its perceived negative effects on health (eg chronic stomach troubles and acidosis). Seen from this perspective, the

preparation of food and drink as a core activity in the care of chronically sick elderly people (compare Table 1) is not as straightforward and simple as it initially looks. It can become an increasing burden for caregivers, creating tension between them and their elderly care-receivers and other household members.

Providers of food

37 More than a quarter of the elderly people in our study prepared their own daily meals (see Table 3). All but two were women, a fact that clearly reflects the gendered dimension of food preparation in Minahasa and Sangihe households. The women were sick but not frail and so still able to cater not only for themselves, but usually for two or more other members of the household (eg aging husband, child or child-in-law, grandchild, or other elderly or unmarried relative). They might need help with other care activities, such as washing clothes or administering medication (see Table 1), but they clung zealously to the daily preparation of food as an important marker of at least some degree of autonomy and independence.

Table 3: People who cook and serve daily meals for the elderly, chronically sick person

Person	Total *N*= 75	MANADO (*N*= 25)	Tahuna (*N*= 25)	Tomohon (*N*= 25)
The elderly subject	21 (28%)	6	5	10
Wife alone	20 (27%)	7	6	7
Child alone	17 (23%)	9	6	2
Wife + child	11 (15%)	1	6	4
Housemaid alone	2 (3%)	--	1	1
Elderly subject + child	1 (1%)	--	1	--
Wife + daughter-in-law	1 (1%)	--	--	1
Child + grandchild	1 (1%)	1	--	--
Brought by sisters	1 (1%)	1	--	--

Source: Author's research data, 2000-2002.

38 As Table 3 shows, in 72% of cases someone other than the elderly sick subject takes care of the preparation and serving of food. This passive age group includes, on the one hand, elderly husbands or widowers who are not used to cooking, and on the other, chronically sick elderly people with severe physical and mental impairments who are no longer capable of carrying out cooking activities. The active meal providers are mainly wives – some of them also suffering from hypertension, diabetes or asthma –, adult female children or an inter-generational combination of wife and daughter. Other food providers, such as non-kin housemaids, daughters-in-law and grandchildren, are only found in very few cases. Kin proximity is a key factor in determining who cooks for the elderly sick subject on a daily basis. Table 3 shows that in the majority of cases (65%) this is exclusively carried out by very close relatives, such as a wife and/or a child. A common explanation for this is that food preparation is related to long-standing positive experiences and personal trust that only close relatives can provide. This socio-culinary relationship embraces flavour and taste, food seasoning, the variety and combination of food and its consistency, quantity and even colour. Also, the correct preparation of dietary food.

> A 72-year old hearing-impaired man from Tomohon: "*I married my wife because she was such an excellent cook (jago masak) when we met. Although I am now old and ill, I still prefer her way of preparing daily food ... the spicy taste and the food variation, just delicious (enak jo)!*"
>
> An elderly former sailor from Tahuna: "*I am used to the food prepared by my wife and daughters – there is always enough, it's always served warm and every meal is tasty (depe makanan salalu cukop, panas dan enak)*."
>
> A hypertensive widow: "*I am not allowed to eat spicy and salty food. Only my daughter knows this and can cook food in the right way (so tau depe cara masak)*."

39 Besides the actual cooking, the physical activity entailed in the serving of daily meals requires a particular effort on the part of the other household members. This is especially the case with extremely frail elderly persons who are either severely disabled or otherwise unable to move (eg hemiplegics, rheumatic patients or those suffering from paralysis after a stroke). Five of the 40 chronically sick elderly subjects (12%) in the tracer illness study were severely disabled in this fashion and required assistance with feeding several times a day. Care activities included placing the person in an upright position, spoon- and sometimes bottle-feeding them, cleaning their face and finally returning the subject to a reclining position. Because feeding is perceived as both an intimate and a humiliating act in which the older person is often implicitly compared to an infant, it is invariably left to close relatives. An intense, long-term care activity, feeding plainly puts the caregiver under considerable physical, social and psychological strain while also shaping their relationship with the patient. On the one hand, therefore, this extreme situation reflects the moral responsibility involved in care provision. On the other, it stresses the power differential that is inherent in the relationship between the two parties.

Elder care and the social life of food

40 In our initial analysis, the preparation of food and drink appeared to be a purely routine, household task. Indeed, on any given day most Minahasa and Sangihe households provide sufficient food for their members, sometimes cooking up to four or five times a day. Guests are welcome at any time and offered a warm meal. Generally speaking, the availability and quantity of food are no longer a problem. [12] In most cases catering for an elderly person forms part of routine kitchen activities. Any deterioration in the subject's health, however, can place an extraordinary burden on caregivers.

41 This approach, however, is not sufficiently differentiated if we shift our focus to the social dimension of food provision in the context of the care of elderly, chronically sick urban subjects. In this case, a proper understanding of food preparation must to take account of the sensitive relationship that exists between caregivers and their elderly care-receivers. The following sections will elaborate on this social dimension of food provision and elder care.

Trust, control and diet

42 Feelings of trust are of particular importance in terms of diet. Trust in this general sense reinforces cooperation between individual actors, making the care and support of elderly subjects less complex and more reliable. Chronically ill elderly persons with particular dietary requirements must trust the foods that are prescribed for them and these in turn must conform to required preventive and curative objectives. Non-compliance with specific, mainly biomedical prescriptions can cause physical suffering to the patient concerned. For this reason, the household member who prepares the patient's food must be fully aware of any special dietary requirements and take full responsibility for ensuring compliance. The dietary requirements in this study related to the quantity of food intake (limiting the size of meals and controlling snacks); the quality of food (avoiding salty soy sauce *[kecap asin]* in soups and chilli pepper *[rica]* in vegetable dishes, cutting down on coconut oil in fish sauces and sweet ketchup *[kecap manis]* in white rice); and the consistency of food (whether flaky, mushy, crunchy or fluid in texture). The following two examples illustrate the daily pattern of meals from the elderly patient's perspective:

> *Ibu* K., a 75-year-old, Protestant Minahasa widow suffering from rheumatic disease, impaired vision and chronic cough: "*My rheumatism is very disturbing and so painful. All day long, I can only sit and watch my daughter's kiosk (warong). I have to take tablets from the doctor who ordered me to observe the following food prescriptions (pantangan makang):*

no meat (dageng), no water spinach (kangkong), no spinach (bayam), and no beans (kacang) – and no spices (so nimbole makang depe rampa-rampa). Three times a day my daughter cooks rice and fish for me in separate pans, even though we eat together at the same table. She has never complained about it. Sometimes, I ask my neighbour to bring me a slice of meat... of course, I know I should not do it, but what's the odds (pinjam hari)! I am already very old."

Bapak H., a 78-year-old, Moslem Sangihe widower suffering from gingivitis (only one loose tooth remaining), gastritis, rheumatic disease, asthma and impaired vision: "*I am suffering from severe dental and oral problems. Thus, I cannot eat normal food such as rice, fish or vegetables, only a little bit of warm soup (sup panas), a plate of not too hot squashy rice porridge (bubur) or sticky sago (papeda). Every time I eat, my mouth hurts, and after a few minutes, my stomach starts aching. I would really like to eat rice and fish, but my daughter will not cook it. Sometimes, I go secretly to a mosque festivity (acara jamaah) where I try to eat some nice tasty food (makanan yang enak). But after that I have pains in my mouth and stomach, and my children are very angry with me.*"

43 As both these examples show, routine compliance with food restrictions on the part of the caregiver is met with partial non-compliance by the elderly person. Officially, caregivers disapprove of such subversive practice on medical grounds ("Your blood pressure will rise again!"). Unofficially, they find such manners intolerable since it not only brings shame *(beking malo)* and disgrace on the caregiver but also threatens to undermine their supervisory role by providing the elderly person with a source of food outside the household.

44 The supervision of elderly subjects through shared mealtimes plays an important role in day-to-day care. Close social supervision can also have positive effects on frail or senile elderly persons: "Sometimes, I forget where I am *(so lupa kita skarang dimana)* after I have left our house ...but just before mealtimes somebody from the family comes to look for me, so I cannot get lost *(so nyanda bisa ilang)*!" In this sense, the social identity of elderly people in Minahasa and Sangihe society is closely interwoven with their attachment to a household, itself defined as a place with a warm kitchen (see also footnote 7). The preparation and consumption of food determines to which household elderly people belong and shapes their social characteristics and identity (eg elderly parents who move in with their children have to come to terms with a new physical, social and economic environment).

45 Very few of the cooks in this study complained about having to cater for special dietary requirements, regarding it more as an essential aspect of elder care rather than a burden. There were a few complaints about the non-compliance of elderly patients with diets: "I have to supervise my ill father closely by sitting next to him and observing what and how he eats. He always wants to eat the hot spicy sauce, but the doctor has strictly forbidden this. He is so stubborn *(kapala batu dia)*!" The elderly persons themselves described such non-compliance as either unintentional and unconscious *("Nobody told me that these cassava chips were cooked in oil [ubi kayu goreng]")* or as a deliberate tactic aimed, for instance, at diversion and distraction, escaping the tight paternalistic hold of other household members or simply annoying their caregivers ("They cannot forbid me to have dried salty fish with hot chilly sauce *[ikang asin deng dabu-dabu]*, it was my favourite food before I became old and ill!" or "At festivities I always eat hot dog meat *[erwe pedis]* – my daughter gets upset but she doesn't dare to scold me in public"). Thus, in many ways, non-compliance allows elderly people to maintain a certain degree of autonomy and level of social participation in the wider neighbourhood and kinship structure. It shows that the elderly sick persons continue to perform as social actors – and not only as objects of control – who deliberately try to make use of their resources and scope for action.

46 Caregivers try to maintain a high level of compliance with diets by using a dominant, legitimate, biomedical tool as a means of exercising social power over their elderly patient: diets only make sense if they are strictly followed by

patient and supervised by carer. In other words, patients on closely supervised diets come under the control of their direct, all-embracing social and physical environment. Defying control through permanent or repeated non-compliance may lead to a deterioration in the elderly patient's social inclusion and continued participation in a household – while also worsening their condition. Nevertheless, their social inclusion in the household will most probably depend on how the other household members react to their non-compliance and what sanctions are used against them. Diets thus acquire crucial significance in the nexus of power, control, trust, and compliance. [13]

47 Current discourse on the medicalisation [14] of elder care in North Sulawesi places lay caregivers in a position of responsibility in irresponsibility: coping with many tasks and burdens but lacking competence and capability. "Healthy-eating" – meaning biomedically appropriate nutrition and diet – is a subject of discourse not only among health professionals and the mass media, but also families and elderly persons themselves. Every urban household with elderly, chronically sick members regularly discusses the popularised views of the health effects of certain foods. Examples range from the impact of salt, hot spices, sweets, oil and fat, or certain vegetables and drinks on the development of chronic disorders to the influence of cholesterol on hypertension, or blood sugar on diabetes or uric acid on rheumatism. On the one hand, elderly persons "hope [thereby] for an increasing commitment on the part of biomedicine to their persistent chronic illnesses" (van Eeuwijk, 2003b: 15), and on the other, caregivers are increasingly shown to lack the skills and capabilities required to provide elderly care-receivers with adequate and appropriate food and nutrition. The dilemma of moral obligation and social pressure to provide care versus the diminished responsiveness and increased demands of the elderly sick puts lay caregivers in particular at a disadvantage. The extent to which the medicalisation of lay care empowers elderly patients more than their caregivers depends on each individual patient's willingness and ability to re-negotiate such delicate power relationships.

48 According to Appadurai (1986), power enters into every transfer of a commodity, including the giving and receiving of food and this in turn affects the trust relationship between the giver and the recipient. [15] Within this context, control becomes a powerful aspect of trust: controlling while giving. The lay caregivers in our study households controlled not only the preparation and serving of the required dishes, but in doing so, also controlled the elderly patients' compliance with diet as a prescribed therapy. By accepting a diet because it is administered by a health professional ("As a physician I know better what is good for these ill elderly people than they do"), chronically sick elderly persons agree to comply with the curative biomedical regime that is imposed on them ("Stop eating salty and fatty fish!"). Food becomes authoritative medicine, its healing power enters the individual body. The caregiver as food provider carries out the therapeutic control process ("You know very well what the doctor told you about your bad food habits!"). At the same time, he/she is in charge of this disciplinary measure in the true Foucauldian sense: the dominant medical system – meaning the state hegemony and its body politics (Foucault, 1976) – disciplines both the chronically sick elderly person and their caregiver and food provider.

Conclusion

49 As demonstrated in this paper, food and nutrition in elder care go far beyond the mere physical activities of cooking, serving and eating food. The mere process of giving, receiving and withholding turns the relationship with food into an aspect of both social life and power and control. Generally, caregivers and care-recipients shape the quality of this support relationship, through such factors as differences in age, health condition and economic resources, or independence and autonomy. Current concepts of care take into consideration the notions of attitude and practice that are inherent in any form of care relation. Both sides involved reflect and perceive, act and behave as social

actors as well as negotiators of power in a relationship where support is expected and provided.

50 For chronically sick elderly persons in need of care and support, the preparation of food and drink is a crucial household activity and a vital form of support. For the other household members, it is an acceptable part of the daily household routine rather than an extra burden. In addition, most elderly patients share the same mealtimes as the other household members and enjoy the same food. Thus, from the perspective of household production, the cooking and serving of food are considered to be routine tasks. From the perspective of the elderly sick persons themselves, such catering does not form part of intimate or personal care and could in theory be carried out by any household member. In practice, however, as shown by our findings, it is primarily the wife, daughter or combination of the two who caters for the elderly patient on a daily basis. Both are very close relatives and tend to co-reside with the elderly person. Social proximity and spatial closeness are important dimensions of the reliability of the food relationship for chronically ill elderly care-recipients. They are exclusively catered for by selected household members, based on food preferences and favourite tastes established over years. Naturally, such a relationship is not only governed by freedom of choice but also by necessity: very frail and disabled elderly subjects or those who live alone are in no position to reject the care provided by any individual who is willing to prepare food for them. Such care is an empirical necessity. But its implications are a gradual loss of autonomy and self-reliance.

51 Elderly patients enjoy the sociability that comes from sharing meals with other household members and guests. Meals primarily represent an occasion to meet and exchange news or discuss important matters and give advice – forums that bring together the worlds outside and inside the house. In short: meals provide the elderly sick with a useful source of information and a platform for communication. For many ill elderly persons, they also serve as "pillars of guidance" bringing a sense of order to what may otherwise seem a very monotonous daily routine.

52 Our findings show that adequate food provision, in terms of availability of food and daily calorie intake, is not a major problem for most of the study households. Those where elderly persons are most likely to suffer from malnutrition are poor, widow-headed households in slum areas with neither the financial means to buy food on a daily basis nor sufficient social capital to make up for temporary shortfalls in food provision and care. On the whole, the quality of food is not an issue. Indeed, being long accustomed to the taste and style of household cooking, elderly patients tend to be highly appreciative of their daily meals.

53 Most elderly, chronically sick persons have to comply with particular nutritional requirements based on preventive or curative diets. Predominantly prescribed by health professionals, such diets must be specially catered for by the household so as to provide elderly sick with reliably "healthy" meals. The caregiver, meanwhile, exercises substantial power by ensuring the elderly patient's strict compliance with diet.

54 A further factor is the increasing medicalisation of lay care, particularly in urban areas due to the availability and accessibility of different biomedical services and mass media information on health related issues. As a result, caregivers and patients alike face growing pressure from professional health authorities in term of complying with biomedically prescribed healthy food and food as medicine. We may conclude that this allows the professional health sector to enter the popular sphere, gradually "medicalising" the lay realm of elder care. In this manner, caregivers are given the responsibility – but not necessarily the competence and skills – to implement what is essentially a medical task.

55 The study has touched on a number of issues that require further exploration. Firstly, gender aspects in elder care and food preparation have not yet been clearly addressed. These relate to the dual role of older women as both the

givers and receivers of care, and the highly gender-based relationship between a healthy female caregiver (and food provider) and an ill male care-recipient, where the power dynamics have to be carefully re-negotiated. Secondly, we need to look more closely at the increasingly important role played by the urban environment in non-western societies as a major influence on household activity. The monetisation of social relationships and the capitalisation of informal social security are already far advanced in urban areas and have a direct influence on both care relationships and food availability. Social and economic transformations such as changes in household composition (eg female-headed household, older married couple household), emerging formal care services (eg old people's home, health insurance) and more (young) women working outside the home have changed long-established care relationships, including the preparation of food and drink for ill elderly people.

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Notes

1 Pyke (1999: 662) characterises families as collectivist that “emphasise close family ties, strong commitment to family members, and high levels of contact and interdependence”.

2 Following the definition of Phillips and Chan (2002: 3), long-term care incorporates health matters, personal care and social services, which are provided at home and in the community over a longer period of time for an adult who lacks, or has lost, the capability to care fully for himself and to maintain his independence.

3 The research team consisted of a group of Indonesian and Swiss researchers and included four medical anthropologists and two public health specialists.

4 Of the initial 42 elderly respondents in the tracer illness study, two unfortunately died in the course of 2001 and 2002.

5 In the year 2000, one US$ was equivalent to 9,500 *Rupiah*.

6 See for instance Tada et al. (2003) or Gross and Dresrüsse (1996: 267) on dental problems; Coleman (2002) on oral problems; and Yen (2004) on sensory loss.

7 For a discussion of the Minahasa household, its definition and local understanding see, for instance, Lundström-Burghoorn (1981: 95-101), Lundström (1982), Lalamentik et al. (1994) and van Eeuwijk (1999: 46-47). The kitchen (*paawuan*; the place where there is *awu* [ash, hearth]) plays a central role in defining the Minahasa household.

8 Popular vegetables are water spinach *(kangkong)*, *gedi* leaves or papaya blooms *(bunga papaya)*. Fish and vegetables are generally called *lauk pauk* in Indonesia and serve as well-liked side dishes to rice, providing a family’s main source of protein.

9 See van Eeuwijk (1999: 133-135) on Minahasa classification of meat, its illness-related meanings, "hot-and-cold" properties, as well as its curative and preventive application.

10 Medical professionals in our team diagnosed that four of them suffered from chronic lung tuberculosis. "Those at risk of TB infection are people who are older, malnourished or immunosuppressed" (Scullion, 2003: 24).

11 Minahasa food (together with Minangkabau food from West Sumatra) is well known to be the hottest food in Indonesia. Minahasa food includes such specialities as dog *(erwe)*, fruit bat *(paniki)*, wood rat *(tikus utan)*, wild boar *(babi utan)*, python *(ular patola)* and thick spicy rice porridge *(bubur Manado*, *tinutuan)*. See van Eeuwijk (1999) and Weichart (2004).

12 For severe food shortages and deadly famines during war- and unrest-ridden times in the 20th century in Minahasa see van Eeuwijk (1999) and Weichart (2004).

13 In a broader sense, food and nutrition present a "fait social total" – a concept that represents and reflects relevant societal dimensions such as economic, religious, legal and social factors. According to Marcel Mauss (1923/24), the understanding of a "fait social" cannot be reduced to one singular factor due to his view that social life is a well organised system.

14 For a current discussion of medicalisation in Medical Anthropology see Nichter (1998). Turner (1995) has conducted a critical analysis of the increasing medicalisation of ageing; see also van Eeuwijk (2003a).

15 Voutira and Harrell-Bond (1995: 211-212) emphasise that the giver who stands closest to the receiver executes the greatest power.

List of illustrations

Title **Plate 1: An elderly ill widow is still carrying out her daily kitchen work (in Tahuna).**
URL http://aof.revues.org/docannexe/image/2052/img-1.jpg
File image/jpeg, 352k

Title **Plate 2: After church gathering in Tomohon these elderly women enjoy a common snack from lunch box.**
URL http://aof.revues.org/docannexe/image/2052/img-2.jpg
File image/jpeg, 176k

Title **Plate 3: White bread and red vitamin pills: an elderly widower on a diet has snack with guests (in Tahuna).**
URL http://aof.revues.org/docannexe/image/2052/img-3.jpg
File image/jpeg, 264k

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